STATE EMS COMMITTEE MEETING

July 9, 2014

1:00 p.m.

Location: Viridian Event Center

8030 South 1825 West

West Jordan, Utah

Reporter: Angela L. Kirk

A P P E A R A N C E S

Kris Kemp

Paul Patrick

Lynn Yeates

Michael Moffitt

Laconna Davis

Casey Jackson

Russell Bradley

Mike Mathieu

Jason Nicholl

Brett Kay

Mark Adams

Margy Swenson

Jeri Johnson

Jay Dee Downs

Suzanne Barton

Wednesday, July 9, 2014; 1:02 p.m.

KRIS KEMP: So welcome to the state EMS committee meeting today, July 9th, 2014. We're going to get started.

We've had a good morning so far with the EMS awards and executive session to kind of hash out some of the details of this committee meeting, so hopefully we can make good use of everyone's time.

A couple of housekeeping items, before we do our introduction of the committee members and additional guests. Please, if you're going to present or speak, if you do not have a name tag that our recorder has access to, please come up to the front and do your presentations and announce your name so that we can make record of that and keep track of everything as it goes along.

But I would appreciate, and I think we would all appreciate, any presenters to please come to the front here of the tables.

And with that, just make sure that you're speaking clearly. And we will begin with an introduction of committee members.

I'm Kris Kemp, Chair of the EMS Committee.

PAUL PATRICK: I'm not a committee member, but Paul -- oh -- not a committee member, but Paul

Patrick, Director of EMS and Preparedness, and Deputy Division Director of Family Health and Preparedness.

LYNN YEATES: Lynn Yeates, Box Elder County Sheriff, representing law enforcement with EMS.

MICHAEL MOFFITT: Mike Moffitt, Gold Cross Ambulance Service and private ambulance providers.

LACONNA DAVIS: Laconna Davis, Department of Public Safety for health communications, and I represent dispatch.

CASEY JACKSON: I'm Casey Jackson, and I'm a consumer advocate.

RUSSELL BRADLEY: Russell Bradley, ER physician.

MIKE MATHIEU: Mike Mathieu, Fire Chief from Ogden, representing the state chiefs.

JASON NICHOLL: Jason Nicholl, paramedic.

BRETT KAY: Brett Kay, nurse, Timpanogos region.

MARK ADAMS: Mark Adams, Ogden Regional Medical Center, representing the hospitals.

MARGY SWENSON: Margy Swenson, Grand County EMS, representing rural EMS.

JERI JOHNSON: Jeri Johnson, Wayne County EMS, representing rural EMS directors.

KRIS KEMP: And it looks like Jay Downs has

stepped out for just a moment, but he's the vice chair of the committee, when he returns.

All right. Let's get right into our action items, and we'll start with the approval of the minutes. I think those have been sent out and reviewed, so unless there are any changes.

MIKE MATHIEU: Move we accept those.

RUSSELL BRADLEY: Second.

KRIS KEMP: I have a motion and a second. All in favor, say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? And any abstained?

All right. Thank you. Subcommittee replacements. Jeri.

JERI JOHNSON: At this time, we do not have any items to review. And in talking, I'd like to make a recommendation to the department that if we could get a list of the available vacancies on the subcommittees within 30 days so I can review them.

MARGY SWENSON: The actual list.

JERI JOHNSON: The, yeah, actual list of the members, and then vacancies. I would like to make that recommendation.

KRIS KEMP: Okay. So we'll need a motion for that as a request, I believe.

JERI JOHNSON: If someone would like to make a motion.

MARGY SWENSON: I make a motion that we request the EMS to provide us with a list of all the members of the various subcommittees and a list of the vacancies.

GUY DANSIE: I was just going to announce that we have a new chair and vice chair of the operations subcommittee for legal as well, so --

PAUL PATRICK: Do the motion first.

KRIS KEMP: Let's finalize the motion first.

LYNN YEATES: I'll second the motion.

KRIS KEMP: We have a motion and a second. All in favor of that recommendation for the motion, say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? Any abstained? Thank you.

Guy, what was that? Would you mind coming up?

GUY DANSIE: Sorry to interrupt. I just wanted to announce that we have within our last operations subcommittee meeting --

PAUL PATRICK: Well, that's Guy Dansie.

GUY DANSIE: Guy Dansie, with the Bureau of

EMS. I have to come all the way up there?

PAUL PATRICK: Yep, you're coming up here.

GUY DANSIE: I'll set the example.

PAUL PATRICK: You've got to get the microphone from Jeri, too.

SUZANNE BARTON: I found one.

PAUL PATRICK: Oh, you got another one. Oh, good.

GUY DANSIE: I apologize. I just wanted to announce that we had elections in the subcommittee, and we have a new chair, it's Chris Delamare, representing the private ambulance service, and also Eric Bauman, you want to stand, he's our vice chair. He's with Ogden City Fire, so -- I hope -- and present them to you for your approval.

JERI JOHNSON: So I'd like to make a motion --

PAUL PATRICK: We have two mics now. We're doing good. We're eliminating exercise.

JERI JOHNSON: All right. So I move to make a motion that we approve the new members.

MARGY SWENSON: Chair and vice chair.

JERI JOHNSON: Chair and vice chair of operations subcommittee. Do we have a --

JAY DEE DOWNS: Second.

KRIS KEMP: All right. We have a motion and second as --

JAY DEE DOWNS: Jay Downs.

KRIS KEMP: -- mentioned by Guy Dansie. All in favor, say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? Any abstained? Thank you.

JERI JOHNSON: One other thing we discussed, which probably will work out pretty good, we'd like to redistribute the current policy to the subcommittees for them to review and recommend a process to help deal with what we currently have. Is that a recommendation or --

KRIS KEMP: So you're making, basically, a motion, then, to redistribute this policy, or is it just that we need to go over the recommendation?

JERI JOHNSON: To go over that within --

KRIS KEMP: Okay. So we can make those task assignments at the -- in the round table section, so if we'll make a point of bringing that up --

JERI JOHNSON: Yes, that's fine.

KRIS KEMP: -- at that point.

JERI JOHNSON: The other was just that we have committee members represented at our -- the

subcommittee meetings for interaction on the action items.

KRIS KEMP: Okay. So the point that you're bringing up with this, that we would like to have committee assignments from the EMS Committee, that we've had in the past assignments to represent the committee in the subcommittee meetings so that tasks are appropriately followed and that there is representation from the committee.

We've had this in the past. It's slipped some because of attendance problems. So what we're looking for, I think, is volunteers to be present and represent the committee on the rules task force, which I believe at one point --

JAY DEE DOWNS: We already have --

KRIS KEMP: We have Jay, so we don't need another one, I don't believe. But we have the grants, professional development, and operations.

JAY DEE DOWNS: We'll welcome more if you want. Anybody want to come down and -- it's a fun-filled event.

KRIS KEMP: Any volunteers for grants subcommittee?

MIKE MATHIEU: I already sit on the grants subcommittee, so I'm more than happy to.

KRIS KEMP: To act as that? Okay. All right. And professional development?

JERI JOHNSON: I will. I was on it prior to this, so I can.

KRIS KEMP: Okay. So you can represent. And a volunteer for the operations subcommittee?

Jason? All right. I believe we need a -- do we need a motion for this, to have them volunteer or to be accepted?

PAUL PATRICK: No.

KRIS KEMP: All right. Great. Sometimes I don't know what we need motions for. All right. So we had that list of volunteers. Anything further, Jeri, under subcommittees?

JERI JOHNSON: I don't have anything else.

KRIS KEMP: And then we'll need to get invites out to each of those people --

JERI JOHNSON: Yes.

KRIS KEMP: -- so we'll make sure that that's on our tasks as well.

AEMT staffing waiver for the Utah Navajo Health Systems. Dustin, are you here? Please come on up.

DUSTIN COGGESHELL: Good afternoon. Can you hear me? No? Can you hear me now? Good afternoon.

I'm Dustin Coggeshell from Utah Navajo Health Systems from Montezuma Creek, Utah. I am the EMS director, director of emergency -- not emergency, but nonemergency medical transport services, Medicaid transports. I'm also the American Heart Association instructor and site coordinator for Utah Navajo Health Systems, and also Dixie Applied Technology College for our area.

I'm here to put a request in for a staffing waiver. We have, as you know, a new ambulance service in the Utah San Juan County Navajo Reservation portion. We have three ambulances, two ALS ambulances and one BLS ambulance.

Currently, we're requesting a staffing waiver for our advanced ambulances, the two that's in Montezuma Creek. It's to have the ambulances operate as a basic ambulance only in times of necessity when no advanced EMTs are available.

And the reason we're putting this request in is because we do have staffing issues down there or hiring problems. We don't have advanced EMTs in our area that are willing to just come and work for ambulance services. So it's usually a lot of our community members that have to be trained by our organization or another ambulance service in the area

and join the ambulance service as an advanced.

Currently, we have one of our advanced EMTs. We have three total going to paramedic school, so that takes them a lot away from our shift coverages. We do have one paramedic in the clinic that works on the clinic floor, and his priority is EMS, but he does other duties for the clinic. And we also have another medical assistant that works on the clinic floor, and his priority is also EMS. So if the pagers go off, they leave for the ambulance calls. And they're also on call for those ambulances.

So with the -- with that request, we're requesting a staffing waiver for -- to downgrade our ambulance to basic life support, if needed.

KRIS KEMP: Okay. Thank you for the presentation, Mr. Coggeshell. I think we have -- it has, and I apologize in advance, created a bit of debate and discussion points among the committee in our executive session, so I open it to the committee now for further discussion and questions or points to be made specific around this request.

MARK ADAMS: Dustin, based on your current staffing parameters, how frequently do you estimate that you'll be requesting this type of a staffing waiver? I mean, will this be a fairly regular basis,

based upon your current staffing parameters, or will this really be a very rare exception?

DUSTIN COGGESHELL: Very rare. With the three we have right now, we have provided 24/7 coverage on our advanced ambulances.

MARK ADAMS: Okay. Because you said you're fairly new, but you are currently licensed as advanced --

DUSTIN COGGESHELL: Yes.

MARK ADAMS: -- on two of your ambulances?

DUSTIN COGGESHELL: Two of the ambulances.

MARK ADAMS: When you originally submitted your licensing application, did you not anticipate having these -- this staffing variance at that time? Can you share with us what your thinking was at that time?

DUSTIN COGGESHELL: No, we did. We actually were wanting to go and operate similar to the same model as San Juan EMS, but we weren't aware at that time that we had to do that special request side on our application, that if need be you would have to downgrade our ambulance to a basic level life support ambulance.

So we thought we'd just go ahead and keep running them as advanced and -- but our goal is to run

them as advanced ambulances as much as possible. But during times, again, when we need to, we're requesting to put them down to a basic ambulance.

MARGY SWENSON: So, Dustin, I'm just a little bit puzzled, I think, that you got three advanced slash -- three advanced providers, and you got two ambulances, and all three of them have other jobs, and one is in a paramedic class. It seems impossible to me, if they ever sleep, that you could provide 24/7.

DUSTIN COGGESHELL: Well --

MARGY SWENSON: And I don't say that without respect. I just --

DUSTIN COGGESHELL: Yeah.

MARGY SWENSON: -- am wondering what's realistic.

DUSTIN COGGESHELL: Well, our -- the other duties that they do, they're under the same organization. The ambulance services operate under the same organization. So like my patient transport department, my dispatcher is an advanced EMT, so part of his job description is also with EMS. So that gives us coverage Monday through Friday during business hours. And the same with our paramedic.

And our interfacility, because we only have interfacility transports to our own two organizations,

which -- two clinics, which is the Monument Valley Clinic and the Montezuma Creek Clinic, that ambulance only runs usually in the hours from eight a.m. to eight p.m., if needed, so those are the only times we need coverage for that one ambulance.

So we really are more covering just the 911 advanced ambulance in Montezuma Creek.

KRIS KEMP: Other questions? Other discussion points?

DUSTIN COGGESHELL: One thing that we do have is we are working on getting an advanced course going here this fall with our course coordinator in Montezuma Creek, and that's been approved through our administration staff and also our board members in Montezuma Creek, funding and everything for that, so soon we'll get that advanced course going in Montezuma Creek and hopefully upgrade a lot of our basic EMTs.

We just completed an EMS basic course in Monument Valley, and we recommended 10 students for state certification. And so far, three of those students have passed their written and practical exams with the state. So once we complete these basic students, then we're going to move on to getting this advanced course going so we have more advanced EMTs on staff for the ambulances.

MIKE MATHIEU: Dustin, typically, when ambulance service providers begin their service, they do have challenges with staffing to build up the staffing numbers to get to the point where they can fully meet the staffing requirements. And that's how our staffing waivers used to work in the beginning, when you'd see in the first two years of operation there would be a staffing waiver until you get up to the full complement.

And then we've also changed our tune, because in some areas of rural Utah there's -- on sporadic periods of time, they have advanced level care personnel available, but it's not consistent enough for the director to say, "We can meet this requirement each and every day."

So what they do is they license to a lower level, and then say, "On demand, when we can staff to a higher level, will you give us permission to do that?" And we've done that with other areas.

But what we haven't done is we haven't licensed to a higher level and said, "Try to staff to that higher level when you can, but it's okay to staff to a lower level when you can't."

One of the concerns I have with this is that it's my understanding that San Juan County used to

provide EMS service at the intermediate advanced level for this area in which you became licensed for. And one of the things you committed to doing when you applied was you wouldn't lower that level of service of advanced life support, intermediate advanced level of support for that area.

And now, within a very short period of time after becoming licensed, you're doing that. So, to some regard, the level of service is being lowered to a lesser level in portions of San Juan County which was formerly receiving intermediate advanced 7/24 every single day. That's a little bit of a concern.

The preference, in my mind, would be that if you truly don't have the ability to stay at the advanced level continually, would it not be better to be more consistent with the rest of the state and be licensed to a BLS level, and then ask for a waiver to provide service at that intermediate advanced level when you can?

What my concern is, and it's honest concern in terms of your staffing capacity and your ability to continually staff 7/24, is that if you really don't believe staff can get to the point where you can staff continually 7/24 at the advanced level, wouldn't you be better off staying at the basic and then staffing at

the advanced level when you can, based on the dynamics that you can't control? Just as you explained, you have more people in class, you've got people off at paramedic school. I wonder if you should be right sized at the basic level, and given the opportunity to have a staffing waiver to perform at the advanced level when you're able to do so.

And that would take less of a burden on what you can -- and try to meet that when you can. And eventually come back and be licensed as an intermediate advanced when you can continually perform at that level with the proper staffing level as your numbers are developed over time.

DUSTIN COGGESHELL: Yeah, we would be supportive of that, making that change and going that route. We think that would work best also.

MIKE MATHIEU: You would be okay with that?

DUSTIN COGGESHELL: Yeah.

MIKE MATHIEU: I mean, a modification?

DUSTIN COGGESHELL: We've that in the past, a few years ago.

MIKE MATHIEU: Because it wouldn't really change how you'd operate, but you would be licensed at the lower level, but have the opportunity to perform at the higher level when you can, and you continually

aspire to operate at that higher level.

DUSTIN COGGESHELL: Yes.

MIKE MATHIEU: And then also maybe when you're not operating at your higher level, your BLS level, you'd have automatic aid agreements to maybe call San Juan in to provide that additional advanced care when warranted on the patient's condition.

DUSTIN COGGESHELL: Yes. With the advanced care meaning that our own advanced EMTs and paramedics would be the ones that would be upgrading the ambulance then from a basic?

MIKE MATHIEU: Right.

DUSTIN COGGESHELL: And we've had that in the past with San Juan County, where Montezuma Creek ambulance has been a basic for so many years, and they've sent a vehicle and a person down from Blanding to upgrade the ambulance, and we're used to that too, so that would work also for us.

PAUL PATRICK: Casey?

CASEY JACKSON: Yeah, I have one question about approval for this waiver. Have you gone to any of your local governments, the county, the tribal councils? Do they approve of this? Because you have a current set that they were aware of. Are they okay with the lowered level of service that you wish to

provide them?

DUSTIN COGGESHELL: Well, we've communicated with our -- one of our neighboring ambulance services, which is Navajo Nation EMS. They're also operating the same. They have basics and advanced. They're not 100 percent advanced ambulances. San Juan County, I think our nearest ambulance is Bluff, also is at times not always an advanced ambulance.

So in our area, our most guaranteed ambulance that could upgrade all the time would be the Ute Mountain Tribe in Colorado. They would be the ones to come down and meet up with us, and we'd transfer patient care to them. And a lot of ambulance services in that area are reliant on the air helicopters to transfer patients out to other higher level of care facilities.

So right now, with the way -- I haven't talked to Linda about it. I've attended one of their local emergency LEPC meetings, but it wasn't a topic then that I've discussed or brought up with them.

But within Navajo Nation EMS, we're both basically at the same level. They're basic sometimes, and they're advanced sometimes, so it's just up and down. And they seem to not have a problem with it. And like I said, I haven't talked to San Juan County

about it.

I've talked to some of the community members, and in the past they've always seen that our ambulances are either basic or advanced, and the majority of the time was a basic ambulance also. So there's really not a change in that area too. And none of the community members or the tribal members, or anybody like that, has opposed the idea of doing the staffing waiver also.

KRIS KEMP: Jason.

JASON NICHOLL: In the past, whenever we've addressed any variances, we've always required, as a committee, required signed documentation from your governing bodies, as well as your automatic aid agencies or automatic and mutual agencies. And I think that -- Casey, I think that that was your question, does your governing body, the county or the city or whoever it is that is your governmental -- whoever you supply to --

DUSTIN COGGESHELL: Our government --

JASON NICHOLL: -- are they aware? And if they are aware, in the past, we have required anybody requesting a variance to actually provide signed documents from them, and I don't see that in your packet, and I think that that's a deficiency that needs to be corrected.

DUSTIN COGGESHELL: Okay. And that would be through the Navajo Tribe. That would actually be through the chapters, and they have a monthly meeting once a month. And we would just present it to them the same way, and they would be supportive of it. I mean, in a rural area that we are in and the way EMS -- it's really, we think, the best service that we're providing the community now, with some improvement we've done after it changed too.

And the local government's always been supportive of it. We don't have any city government. We don't have -- we have county, but that's kind of different with our reservation portion. It's more of our chapter officials and our council delegates through the Navajo Nation.

KRIS KEMP: Any other concerns or questions for Mr. Coggeshell?

JERI JOHNSON: I feel, coming from a rural director position, I would feel that you need to coordinate as a county as a whole as far as -- because are you all tribal, the land that you cover?

DUSTIN COGGESHELL: We're -- yeah --

JERI JOHNSON: You have no public --

DUSTIN COGGESHELL: -- our jurisdictional area, I would say, about 80 percent is all tribal.

JERI JOHNSON: But there is some public --

DUSTIN COGGESHELL: There's some public --

JERI JOHNSON: -- county lands?

DUSTIN COGGESHELL: There's some county lands, but nobody lives in those areas, unless there's a traffic accident or something, or a tourist.

JERI JOHNSON: But you've got highways?

DUSTIN COGGESHELL: We've got highways.

JERI JOHNSON: And I feel, just as a governmental -- working with your tribal and with the county government would be a better overall perspective, working together and getting to hear from both the county government and the tribal, as far as the support documents and having to provide care, the best care for the people and for those citizens.

KRIS KEMP: All right. Thank you for the comments. I think that's covered just about all the topics we had in regards to this. So what we need to do is create a motion for recommendation.

First of all, based on the staffing waiver that was presented to us to continue at the advanced certification level, but to waiver down to the basic level when needed, do we have a motion for approval for that? No motions for approval as it's presented.

Okay. Do we have an alternate motion for

recommendation for Mr. Coggeshell and his agency that he represents, based on those discussion points that were brought up?

MIKE MATHIEU: Thank you, sir. I'd like to make a motion to be consistent with our staffing rules and to ensure that we adhere to them, and I'd like to make a motion that this license be changed to a basic life support license, and that they live within the staffing requirements within that, and be allowed a waiver to operate at an advanced level when they are capable and they have appropriate staffing to do so, until which time they come back and apply for a license at the advanced life support level when they can actually meet the complement of staffing requirements.

KRIS KEMP: So we have a motion. Are there any adjuncts to that motion, including mutual aid discussion and/or letters from community?

JASON NICHOLL: Yes. We need the letters. We need the hospital, the district, the mutual aid agencies, and the government, everything would have to come to a -- for a standard variance.

KRIS KEMP: And working through the department.

MIKE MATHIEU: I would adopt that, or I'd agree to that friendly amendment to that. I think the

most important thing I wanted to take care of first is -- but I guess we won't have a discussion on the motion until we have a second.

MARGY SWENSON: I'll second.

KRIS KEMP: A motion, with the amendment as stated, and a second.

MIKE MATHIEU: Now, we can discuss. The important thing is, I think we need it here and allow him to function tomorrow and today at the level they're capable of, and live within the rules, knowing that they can't meet the staffing requirements under the current arrangement. That was the most important thing, I think, that needed to be addressed.

Secondly, I think their governing bodies, their neighboring partners, need to be informed of this change of their level of service licensure, and that they can work with them and allow them to know that there's a change. And at least minimally in those areas that 20 percent of the county area that are being served, that the county be involved in potentially backing up mutual aid, automatic aid for that area with advanced level service to aid in the basic life that they would have to provide. And I think that's something that needs to be decided upon at the local level.

But most importantly in the motion, I think, is let them be licensed at the level they're capable of serving, and then they can come back to us for an upgrade of that license or the Bureau to change licensure when they're capable to do so.

KRIS KEMP: That's a great explanation on the full motion and amendment, which has been seconded. Any further discussion before we go for a vote?

All right. A vote on the motion as noted. All in favor, say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? Any abstained?

Motion carries. Thank you.

DUSTIN COGGESHELL: Thanks.

KRIS KEMP: Subcommittee reports and action items. Rules task force update, R426-4, draft rule revisions. Guy?

GUY DANSIE: Apparently, we neglected to put our operations subcommitte report on here, so first I'd like to have, if that's okay with the committee, have Chris give a quick, a brief overview of what we talked about in our operations subcommittee.

And then we have -- the rules task force actually has an appointed representative, Dean York, from Provo Fire, and I'd like to delegate to him to

discuss the rule. We've decided not to propose it for a vote because we felt like it needed some more work, but go ahead and invite Chris to come up and -- Chris Delamare from Gold Cross to discussion operations subcommittee agenda items that we discussed last time. Thank you.

CHRIS DELAMARE: If I talk loud, do I have to use this? Can you hear me? Actually, we just had two items that we discussed. One was the, I guess, ambulance certification, the KKK standards, to adopt, I guess into the rule, if I'm not mistaken. Help me to remember, is that right, Guy? It was because of the rule we wanted to look at --

GUY DANSIE: Yes. As we developed and started working through some of the rules in the rules task force, that became an issue, so we referred that back to the operations subcommittee.

CHRIS DELAMARE: Okay. So we looked at the -- we kind of briefly talked about the KKK certification, as well as there's the NFPA standards that are coming out. But because the NFPA was not, I guess, in place for another year or upcoming, we felt like just if the rule was already stated in KKK, to stay with that until NFPA would come into play and say we need to look at both options. So right know we're

kind of just standing pat, if KKK was still in the rule for that aspect.

The other part of it was, the second thing we talked about was this -- the EMS performance measures, and we came up with a survey. We -- there was 25 questions presented to us. We chose five of them. Most of your agencies, if not all of your agencies, probably should have received that survey by now. And I believe Matt Christensen is going to talk about that and kind of give you the details on it.

But there were five questions that we felt were at the time appropriate to ask that we kind of wanted to know, and I believe that was from -- it's been handed down to us from you guys to make sure that that was taking place, so -- any questions on that?

I'll turn -- I'll let Mike -- or Matt discuss that part. But that's kind of what we discussed in our operations subcommittee.

KRIS KEMP: All right. Questions regarding -- or concerns regarding what was reported from operations subcommittee?

Okay. Thank you. And then the rules task force update.

DEAN YORK: Dean York, EMS task force member, Provo City EMS coordinator. So here's your update, and

that is temporarily the rules that we've worked on have been pulled due to some of the wording, some of the concerns from Brittany, the lawyer that's the legal representation for the Bureau. We had a change from Lyle, who retired, and there's been some changes there now with Brittany coming in, and so things that have come up that need to be changed are her concerns, and that's what we're tasked to do, is to try to keep those in a legal aspect.

KRIS KEMP: Okay. Discussion points about the rules task force? And I think specifically, Paul, you had the actual statute, I believe. If you wouldn't mind reading that again so that we can remind ourselves of the point of the rules task force and who they are representing.

PAUL PATRICK: All I know is it's close. It's right here. It's okay. I'm good. Okay. In 26-8a, Section 105, under "Department Powers," it says, number 3, "The Department shall establish a voluntary task force representing a diversity of emergency medical service provider to advise the department and the committee on rules and adopt rules in accordance with Title 63G, Chapter 3, Utah Code, Rule-Making Act.

KRIS KEMP: I think that that statute, one of the most operational words is the term and the word

"and" when it comes to who they -- that the task force is to receive assignments from.

And currently they've received most of their direction from the department, and yet there is still plenty of direction that this committee can help in guidance of the task force, which was brought up before.

That was part of the reason why Jay Downs was appointed to the task force as a representative of the committee, yet there is still some opportunity for us to provide assignments to the rules task force as we see fit.

Currently, I believe the majority of what the rules task force is covering from the department has to do with the public comment pieces from the prior two revision committees that were involved in the rules, but there is still additional work that can be made or assignments made from this committee.

I specifically have one that will hopefully be as a task to Brittany, the representative of legal counsel, and that is specifically who -- would it be department or through this committee that we would further define the relationship of physician and ambulance, you know, if there's a physician that is in the back of the ambulance or ends up assisting an EMS

crew in any situation, as well as a nurse ambulance relationship.

I think that there's quite a few topics that have been brought up recently about nurses in the back of ambulances, and I think some further delineation of who would task that better, through the committee or through the department, and whose responsibility, especially with potential rate changes, with other specialized providers in the back of ambulances. I think that would be important so we can get that back to Brittany as a task directly, specifically in regards to those two points.

Are there any other points or tasks specifically for the rules task force that we want to entertain?

MARGY SWENSON: Yeah. I can just speak loudly. I just wanted to --

KRIS KEMP: You're good.

MARGY SWENSON: -- specify that -- sorry.

KRIS KEMP: No, you're good.

MARGY SWENSON: -- specify R.N., in terms of not just nurse, but specifically registered nurse, I think, or, if you want, L.P.N., instead.

KRIS KEMP: I think that is appropriate.

MARGY SWENSON: Okay, good. Thanks.

KRIS KEMP: So that would be a task to the rules task force for Brittany specifically to answer the question, and then we'll further define from that point.

Anything else for the rules task force?

BRETT KAY: I'm wondering, given the discussion about direction to the rules task force, if it wouldn't be a good idea to have Brittany come to this committee, explain to us, if there are several or many legal issues with the current rules, to make us aware of that, and then we can turn around and redirect the task force to address those issues. I think it would make me feel more comfortable, at least, in that role directly before the task force goes off, you know.

KRIS KEMP: And I believe she was planning on being here, but she's on vacation at this time. But I think that's a reasonable request as well.

PAUL PATRICK: I'll make sure that that happens.

KRIS KEMP: Any other questions, concerns at this point for the rules task force?

All right. Thank you. Grants subcommittee. Allan.

ALLAN LIU: Good afternoon, I'm Allan Liu, financial analyst here at the bureau. Ron Morris, the

grants subcommittee chair, could not make it today, so I will be giving the information.

You should have received information, the grants subcommittee minutes, and then two spreadsheets, breakdowns of grant funding.

What I need from the -- what I want to talk about is that on June 3rd the grants subcommittee met, and from the Office of Financial Operations, OFO, we only have $900,000 in grant funds for fiscal year '15. The fines and forfeitures were significantly down this year, and all that's available is $900,000.

The grants subcommittee recommended splitting that in half, 450 for the competitive grants and 450,000 for the per capita grants.

With the $450,000 number, we looked at the categories and amounts requested and we kind of broke it down on how we were going to spread the 450,000 based on that -- on the proportions that way.

We met all day on the 3rd of June, discussing things, and for everybody, the written explanations of grant requests really help a lot, and so that explains why some got funded and some agencies received funding and some didn't, just based on points given and the narrative given.

We also talked about suggestions of

improvement. And what I need from the committee is to approve the competitive grants and per capita grant breakdowns. But first, do you guys have questions on this at all?

KRIS KEMP: Any questions specifically for grants based on what you see before you, specifically on the breakdown 50/50 for competitive and per capita? Questions? No. Okay.

JASON NICHOLL: Do you want to split the motion competitive and per capita or combine it?

PAUL PATRICK: We can combine it.

KRIS KEMP: It can be a combined motion.

JASON NICHOLL: I make that motion.

KRIS KEMP: All right. We have a motion to approve the 50/50 recommendation of per capita and competitive grants for 900,000. Do I have a second?

PAUL PATRICK: Did you get the -- Jason, it was Jason?

COURT REPORTER: Yeah.

JAY DEE DOWNS: I will second that. That's Jay Downs.

KRIS KEMP: We have a motion and a second. All in favor, say aye.

COLLECTIVELY: Aye.

KRIS KEMP: Any opposed? Any abstained?

All right. And then the description of the grants themselves, as recommended by the grants subcommittee and how they would be disbursed.

PAUL PATRICK: That was all in the motion, right?

JASON NICHOLL: Yeah.

KRIS KEMP: Or that type of thing, so it's not just fiscally? All right. We got that accepted, terrific.

ALLAN LIU: Thank you.

KRIS KEMP: All right. Thanks, Allan. Informational items. Paul.

PAUL PATRICK: Thank you. In June of 2014, the Office of Legislative General Audit completed their audit report, performance audit, on Bureau of Emergency Medical Services and Preparedness.

Myself and Dr. Patton, and Jolene Whitney was there as well, were at the committee that Representative Lockhart and Senator Niederhauser chair, along with Representative Clark. Was it Clark? One other representative was there.

And we present -- the auditors presented their report. A couple of people here were there at that meeting as well.

In the audit report, there are 47 pages, but

there are 15 recommendations, of which we accepted the recommendations. And I just wanted to briefly go through what our plans are as we work through that. And page 19 will have the audit report. On page 19, there's a recommendation to the department that we do more formal corrective actions, restrictions, probations, suspensions, and other things.

One of the things that we propose to do is form a new compliance investigation and enforcement unit within the department to help us do the complaint process, and I'll be doing some shifting of staff and reorganization that I'm not prepared to announce at the present time today, but we'll get it out to all of you when we do that to bring people into those positions, and we'll be hiring a couple of new people to help us with investigations to do that.

The second recommendation was that we consider changing the -- amending the Code 26-8a-407, where it says that it's the goal of the legislature that municipalities should establish cost, quality, and access goals, that we make it -- they were recommending we make it mandatory that communities or governmental institutions will establish cost, quality, and access goals. So we'll work through the Department of Health's rule-making process to see -- not rule-making

but legislative process to see if that's something that a legislator will want to take on to add to the codes.

The third item is a recommendation that those -- that we document that. And one of the -- if you read the entire report, I've identified, in the last couple of pages where I did my comments, which start on page 43 and go through page 47, I'm not going to go through that, but we will be having a licensing officer that will be assigned to do that, so the licensing officer will be assigned to do number three.

Number four is that they are concerned about the financial solvency of agencies and don't feel that our current fiscal reports meet the standard of what agencies should be reporting financially, and so I've agreed to assign a financial officer and we'll have the financial officer be able to look into that.

The fifth recommendation was having to do with equipment. They were very positive on our inspectors out there, but felt like we needed to go into more depth into the inspection process, and such things as defibrillators, we needed to look at serial numbers. And so again, I will be assigning an inspection officer to do that, so current staff will get new assignments to do those things.

The sixth one is a responsibility for Guy

Dansie to review the standards required in the Utah Code to ensure that the Bureau processes early detection of any provider deficiencies, since Guy is currently over the EMS program section.

The seventh one was to improve the documentation of our complaint process so the new CIE unit -- I tried to get something really jazzy, so we may change the name on it -- but the new unit will be involved in helping us with the complaint process and the ambulance regulations.

It was very clear in the report that we have statutory authority, but need to take more actions against providers, agencies, and individuals if they're in violation of the statute, that we don't need more authority, we just need to be more regulatory. So this group will look at that. We agreed to have that.

The eighth one was recommended directly to me personally because I let -- I gave Layne Pace an e-mail of a complaint before it was released, and Layne Pace got it three days before it went out to the public. And I've apologized and taken my 30 lashes and will never do that one again, so that was resolved by the fact that we'll make sure that never happens, and it went to Layne from Orem Fire.

This ninth recommendation was again about the

complaint policy. And the tenth was to post all of our complaint policies on-line, and the new CIE unit will do that. And other states have posted violations on-line, Texas does that, Michigan, and many other states do that, by individual and by agency. It didn't go into that detail, and before we do that, I would seek the advice of this committee, but to actually put on their website, you know, EMT Paul Patrick violated this, and so and so did that, and they go to the point of posting it all on their website. So they didn't direct us to go that far, but I would seek this committee's advice before we do that.

If you turn to page 32, this is in chapter three, there were five more recommendations that we felt that -- number one would go to the licensing officer, that we consolidate redundant licenses into a single license, and the rights and responsibility be conveyed by the providers on that license.

Whereas now many agencies have multiple licenses with multiple numbers, they think there was some confusion because of that. An agency could have one license, and then it would list all of their responsibilities, all their aid agreements. So it's really not changing -- I'm looking at Jay, so -- you know, Cache County EMS has like two or three license

numbers. They're recommending that we consolidate those into one number, but still list the authority that you have under all three of them in the license. So it's not taking away or adding anything, but it's consolidating into a better license process. And again, I've consulted with Brittany Huff, who is the attorney general representing us, to help us legally be able to do that.

The second one is to -- the only one that directly comes to this committee, and if you read my reply, I didn't ever -- I did not say that the committee would have to adopt Utah County hearing's outcome, but they want to recommend that you adopt Utah County's hearing outcome and define in rule the relationship between ground ambulance and interfacility transport licenses and have that more done by rule.

So currently in Utah County John Bates is an attorney on contract with us, and he is the hearing officer, presiding officer, in a hearing in Utah County where the -- all the licensees are providing information for him to help sort out issues that exist there.

Once that's done, I will have John Bates come and make a report to the committee. I would never dictate what you have to approve, adopt, or what -- any

motion the committee would do, but while bringing him here. But then once that -- that issue is resolved in Utah County, the one thing I agreed to do was work with the rules task force as a department to give them the assignment to help us in rule define the relationship between ground ambulance and interfacility transport license. So we'll get that more clarified by rule. But we need to wait until that hearing is complete. And I know they're in the process now, and we want to let that process take its full course.

Number three has to do with ambulance providers document and verify documentation of the aid agreement, it says mutual aid. Because of the statute, the rule calls them aid agreements because they happen more than just in times of unusual demand.

One of the things we were hoping to do is change in statute the term "unusual demand" because aid in a lot of areas, including Salt Lake County, you have a lot of mutual aid agreements, and so really nationwide aid agreements take place, and it's not really an unusual demand situation, so we've kind of skirted around the statute with that, so we'll work on getting that revised as well. Our licensing officer will be responsible for that.

And also, on number four, we recommend that

the Bureau use the various -- work with dispatch centers and others to do a mapping solution. The state of Arizona, on the back of all their licenses, has a map of the geographical area that an agency provides coverage for, others in the north, south, east, west coordinates that we have.

Sheriff Yeates does a great county mapping book, and so through him, and also Shari Hunsaker has been working on some ways for us to do that, so we've accepted the assignment to eventually have a map on the back of your license so -- or as part of the license package, because you won't have a front and back on the license, that will have a map so you can look at your area, or look at the area for an entire county, and make sure and see where everybody says it will be graphic, instead of just by word.

And the fifth requirement was that we continue to document and image the documents that we do that provide -- that are the provider documents. And Shari Hunsaker is our records management officer, and she will continue to do that.

So other than going into ad nausea the remainder of the audit report, the committee, Becky Lockhart made a motion, it was seconded, and the committee approved the audit, and then I have a

responsibility to go back on a quarterly basis to two subcommittees of the legislature. One will be health and human services, and the other is the health appropriations, and report on the progress that we're making on this audit. And so we've accepted to do that. And I will also keep the committee apprised of the progress that we're making.

And as soon as we get the full restructuring of our organization within the next couple weeks, of EMS and Preparedness, I will send you out a new organizational chart so you can see where everybody fits. And then we will be recruiting for at least two new employees who want to work for us as inspectors in our licensing -- not in our licensing, but in our CIE Unit, or Compliance Investigation and Enforcement Unit.

So that's my report. Any questions?

KRIS KEMP: All right. Thank you, Paul. Matthew Christensen, with your performance measures update.

MATTHEW CHRISTENSEN: Hi, everyone. I'm Matthew Christensen, and I'm an epidemiologist with the Bureau of Emergency Medical Service and Preparedness. I'm going to provide an update about the -- how we're starting to use Utah data regarding national performance measures for EMS that we talked about at

the last committee meeting. If I can get it to stabilize. I think we might need some technical assistance. Is it going on and off for you like it is for me? Okay. We will make it through one way or another.

So I want to provide an update to how we're starting to use our Utah data as it applied to these national measures. You'll remember at our last EMS committee meeting in March I, at the end of that meeting, shared with you the 35 measures that are in this report, there's actually 36 individual measures that are categorized into different groups.

This was a report published in 2009 by the National Highway Traffic Safety Administration. And from 2002 to 2007, for a period of five years, they convened work groups, pulling people from across the country, to help make decisions on what these performance measures should be for EMS to set the national benchmark.

And we presented this briefly, as I said, at the end of the last EMS committee meeting. We didn't have time to really make decisions at that point, so the decision was to bring it to the EMS subcommittee, where we would have time to make decisions and start to move forward.

So we had a good discussion at the EMS subcommittee, it lasted for about an hour, and talked through all of these 35 measures, and a handful of them were selected. And we went back to see what data we had, if we could measure all these. And for most of them we do have data, and we're going to share that with you today. A few of them, we don't have data, though, and as we go through this I'll explain which ones those are.

So starting out, this is the number five performance measure from the NHTSA report, what percentage of patients who meet 2011 CDC ACS triage criteria for transport to a trauma center are transported to a trauma center. So this is just looking at these triage guidelines and the percent of patients that meet the triage guidelines, how many of them actually get to a trauma center when they're supposed to get to a trauma center, according to the guidelines.

This was -- the field triage guidelines were updated in 2011. This was published in the MMWR, this is a weekly CDC journal, in January of 2012. There are four steps in the field triage guidelines. And we're going to look at step one data, the patients in Utah that met this step one criteria.

We currently don't have all of the indicators for step two. With the move to NEMSIS 3 that's happening this year in Utah, we will be able to look at the step two triage criteria at that time.

With step one, there are three specific measures, so if a patient meets any one of these three measures, Glasgow coma score, systolic blood pressure, or respiratory rate, then they come over to the yes box, and the recommendation from CDC is transport to a trauma center. Steps one and two attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system. So that's what we're looking at, is just these patients that met this step one criteria. And we have data for 2011, 2012, 2013.

The red bars represent -- let me start with the blue bars. The blue bars represent the actual number of patients in 2011 that met this step one criteria and were transported to a level one or level two facility. The red bars show the actual number of patients that met this step one criteria that were transported to other hospitals in the state. So across the three years, we're looking at about 45 percent of these step one patients going to a level one or level

two trauma center.

We know that our level twos and our level ones are along the Wasatch Front, so Weber, Davis, Salt Lake, Utah Counties, and the population in those counties are pretty well covered by a level one or a level two center, that's about 76 percent of the population in those four states -- or excuse me, four counties. So that gives you kind of a comparison level to this in terms of the number of patients that could be going to a level one or a level two trauma center.

Moving to the next performance measures in this report, 6.1, 2, and 3 look at pain management and how well we're doing with pain management for patients. Comparing first and last pain scale values, what percentage of patients older than 13 reported decreased pain, increased pain, or no change in pain. So this is focusing on patients where there were at least two measures of pain, and it's simply looking at the first and the last measure to see if there's a change.

SUZANNE BARTON: He's going to correct that for you. Just a second.

MATTHEW CHRISTENSEN: Okay. These -- this data point, pain, is not a required data point in Utah. So the data that we do have are for agencies that are collecting this and reporting it into the system. So

it doesn't represent all EMS agencies in Utah.

For the three-year period, 2011, 2012, and 2013, these are the number of patients that had a first and a last, at least two measures of pain. And the green part of the bar shows no change. If they said they had a five when they were asked first on a scale of one to ten, in terms of how bad their pain was, they were a five the last time when they were asked.

The red part of the bar is no change -- or an increase in pain, excuse me, so if they were a five the first time, they might have been a seven the second time, or some increase. That's 10 percent of the patients that were reported.

And then 40 percent of these patients reported a decrease between the first and last pain values. So it gives you an idea how we're doing with pain management.

Moving to the next measure, what is the rate of undetected esophageal intubations? We had some discussion in the EMS subcommittee about this, because it didn't make sense initially, just by looking at this, where we would get this data, because if it's undetected, how would we know what the rate of esophageal intubations were?

And we thought that maybe this data would

come from the emergency department. In fact, that's not the case. It is reported into Polaris. And a better way to think about it is not so much undetected esophageal intubations but delayed detection.

So there are two ways that Polaris collects data for esophageal intubations. You immediately detect that it's an esophageal intubation and then you report it and you correct it at that time, or the delayed detection, so that's what this report is looking at, is this delayed detection. It's an esophageal intubation, you don't recognize it immediately for some period of time, and then it becomes evident, and at that time you correct it. So that's what we're looking at.

In 2011, there were seven reported. Six in 2012. Five in 2013. And you can see what the ratio is. The top row shows the total number of intubations attempted in those three years.

PAUL PATRICK: We're getting you hooked up there. They -- we don't see anything but the blue screen.

UNKNOWN MALE: Sorry, unfortunately, some problems.

MATTHEW CHRISTENSEN: Any questions? Any comments?

BRETT KAY: Do you report out like the misses, are they advanced EMTs, are they paramedics, are they, you know, I mean, is it fire department, I mean, is there something that you can do to decrease that even more?

MATTHEW CHRISTENSEN: Specific to this esophageal intubation?

BRETT KAY: Yeah. I mean, are the five, are they advanced EMTs or are they paramedics?

MATTHEW CHRISTENSEN: The information is in there. We don't -- we don't have it here today. But yeah, it's certainly in there. We know exactly, reportedly.

So the reason -- part of the reason we reported this, we're at the beginning I was looking at this data, but the idea is, moving forward being able to use it constructively, when it makes sense to do that, to try and improve performance. So that is something we could do.

In the EMS survey that was sent out to all EMS agencies as well, this was a recommendation that came from the EMS subcommittee that we send out a survey to the agencies and ask a couple of questions. One of the questions: What does your agency do to detect esophageal intubations?

188 people received the survey -- or excuse me, 188 people were representing agencies, EMS agencies. 77 responded. Ten skipped this particular question. So we have 50 agencies that responded to this.

The most common method for detecting esophageal intubations, as reported by these 50, was end-tidal C02 or capnography. 42 out of 50 recognized that.

The middle bar shows that about 25 of these agencies reported observation of sounds and movement by mist. And then six reported video laryngoscopy.

Going forward, number 16.1, what is the rate of EMS crashes causing service delay for 1,000 responses? There are a couple other crash related questions in this NHTSA report, and they rely on self-report survey data. So we had some discussion about crashes in the EMS subcommittee.

Currently, what we have available is for this 16.1 measure, looking at crashes that cause service delay, so that's the measure in terms of how significant a crash was, because that's part of what our discussion was, well, what would be -- what would be reported for crashes? Just something little? But in this case, it's significant enough to actually cause

a service delay.

In 2011, there were not quite 70 reported. 2012, about 60, and then almost 120 in 2013, for an average across this three-year period of four in every 10,000 runs.

Part of our discussion in the EMS subcommittee about crashes was some discussion about the lights and siren use. This graph shows every EMS agency in Utah and the percent of their runs in 2013 where they used lights and sirens going to the scene. So -- well, the first bar on the left is the state average, excuse me, and it's 58 percent, so that's how it's represented.

Moving from left to right is the larger agencies going to smaller agencies. So you can see there's quite a bit of variation in terms of lights and siren use in 2013.

PAUL PATRICK: Your left, or the left on the screen?

MATTHEW CHRISTENSEN: For the slide, moving from left to right. It's largest to smallest.

PAUL PATRICK: Thank you.

MATTHEW CHRISTENSEN: So the biggest agency in the state is at 20 percent of the time on their runs to the scene used lights and sirens, quite a bit below

the state average. You can see how it varies a little bit.

As you get farther to the right of the slide, there are a handful of agencies that are at 100 percent, or nearly 100 percent, but it does vary quite a bit by agency in terms of lights and siren use going to a scene.

This is the exact same thing, looking at lights and siren use from the scene. The state average is five percent. So if you see lights and siren use, chances are it's much more likely going to the scene than from the scene. Obviously, not always the case, but based on this information, that's what's going on.

And again, as you go farther to the right of the slide, smaller agencies are much more likely, or at least a handful of them, to use lights and sirens quite a bit going from the scene.

This was another question in the survey that was sent out to EMS agency: Does your agency base its lights and siren use response mode on the emergency medical dispatch system it uses?

Those who answered the question, 72 percent, yes, that they did base their lights and siren use on their emergency medical dispatch system.

And the last measure that we were able to get

data for, 17.1, was the number of primary complaints for which EMS responds. So for the three-year period, 2011 through 2013, the number one primary compliant, which is probably not a surprise, is transfer interfacility care at around 80,000, almost 80,000, for the three-year period. The number two primary compliant is traffic accidents. So those two are pretty much ahead of all the others. Those are pretty clearly the two most common calls for this three-year period.

The number three most common primary complaint is a fall victim. Sick persons, number four. And then number five is a breathing problem, at around 37,000.

If you walk out to number 11, 22,466, that's traumatic injury, the 11th most common primary complaint. 13 is assault, at just under 15,000. And then bumping out near the end is 9,903 for cardiac arrests. So it gives you an idea about what's most common and how things compare to one another, in terms of the frequency of the calls.

Are there any questions or comments? Yeah.

KRIS KEMP: How did these rank as far as how we look nationally, how do they compare?

MATTHEW CHRISTENSEN: As far as I know, I

haven't seen any national data on this yet, it hasn't been done.

KRIS KEMP: So we get the questions from the national EMS, but we don't have any reported data from anywhere else?

MATTHEW CHRISTENSEN: As far as I know, they have not put this -- they have not put these measures out, in terms of where the standard is for -- for the nation on these measures.

Other questions? You're right, though, the comparison would make this information -- if we compare, it would give us an idea about how we're doing relative to the nation.

KRIS KEMP: Yeah. I mean, I think it's useful that, you know, esophageal intubations, it looks like they're on the decline. I think that, you know, the standard of care generally would be end-tidal C02 monitoring, after a -- some form of direct visualization, whether through video or through direct laryngoscopy. But, you know, I think that to use some of this data, we've got to know kind of where our benchmark truly is.

MATTHEW CHRISTENSEN: Yeah. We can put an inquiry in and see if they could do that nationally, because they have a website for NEMSIS, and we report

some of these data to a national -- I don't know if they would be available for all of these, but some of these we might be able to.

I didn't mention, there were several of these, as we were looking at our data, will be able to measured with the NEMSIS 3 data standards. So we can't look at all of the 35 measures currently, but moving forward, we'll be able to look at a lot more, so some of these, even though at a national level they couldn't -- wouldn't be able to put these together.

BRETT KAY: On the lights and siren use, what can you share with us about what is considered a safer practice? I don't know, is it better to have lights and sirens on, or is that -- or is that worse from a public safety perspective?

JERI JOHNSON: No one hears it.

MARGY SWENSON: Nobody hears it.

BRETT KAY: I was just curious. You gather the data. Do you try to go towards one or the other?

MATTHEW CHRISTENSEN: Well, it's around minimizing risk and crash risk, and crash risk increases with lights and sirens use. So the more we use lights and sirens, the more likely to crash and cause problems. The data is pretty clear on that.

KRIS KEMP: Okay. Any other questions?

Comments?

JAY DEE DOWNS: Interesting.

KRIS KEMP: All right. Thank you for the report. Wasatch Front catastrophic earthquake plan effort, Dean Penovich.

DEAN PENOVICH: I'm Dean Penovich with the Bureau of EMS Preparedness. I'm hoping all of you have a sheet on your -- in front you on the table that says "Catastrophic Earthquake Planning, ESS-8 Draft Work Plan." But I wanted to take a few minutes and discuss what we're doing and make sure you're informed and aware and helping us with our efforts, so...

Region 8 FEMA and Health and Human Services came to the state and said, "Hey, we want to revitalize this earthquake -- catastrophic earthquake plan for the Wasatch Front, and we want you to be involved in that.

So we said, "Well, that's fine and dandy, we're excited to do that." We want to make sure that our local agencies are involved in this process, local, state, federal.

So on the first part of this page, this is our objective, our prime goals, our strategy, personnel, et cetera, and I just want to go over those just briefly and spend most of my few minutes on the back side of this page.

But our goals really are to really get with you all, with other partners, to establish how we're going to maintain situational awareness when the earthquake happens and provide support, both -- well, in all three areas of life saving, life sustaining, and mass fatality operations. So we took this to our public health preparedness advisory committee meeting, which you all have a representative on that. Chris Delamare actually came to our meeting, and we're grateful he was there, to give us some input.

So if you want to turn that over to the planning work groups, I just want to review those briefly with you and have you think about who might be good individuals from your agencies that might want to be part of these work groups to help us with our planning efforts.

So you can see there's a list of eight work groups. I'll just read the heading of each one. The first is health assessments and situational awareness, which EMS has already identified as being a part of that work group. Acute medical care, the very first agency listed there is EMS. The third one, patient movement and evacuation, which lists EMS as well. Medical logistics, which has EMS identified on that work group. And then the last four are medical care

support, behavioral health, public and environmental health, and mass fatality services.

So in our advisory committee meeting we went through these and said, "You know, where does EMS really have a major role in this? Where can we have someone from the EMS agency sit on a work group to help us write this plan?" And that's what we've identified. We've identified the need. We haven't identified an individual. So it wouldn't hurt, I think it would be really good for this committee meeting, if there's -- if you look through those -- at least those four work groups and thought, hey, I've got someone, I know someone that might be a really good representative, representing EMS, to be on the planning work groups. I would love to hear that. So that's the kind of the nuts and bolts of our activity in planning for the earthquake.

I wonder if you have any questions about what I may have presented or that I have to offer anyone? No questions.

But if there is someone that -- if you thought of someone in your agency that might -- you might volunteer to be a member of our work group, we'd love to have them involved with us.

KRIS KEMP: All right. Any volunteers

currently, or we'll just think on this one for a while? All right. We'll consider it. Thank you for the report.

DEAN PENOVICH: Thank you.

KRIS KEMP: Uh-huh. EMS ambulance rate changes, Allan.

ALLAN LIU: All right. So it's not blinking anymore. That's great.

SUZANNE BARTON: Do you want the lights off?

ALLAN LIU: Yeah. As everybody knows, you've seen these slides before, the cost of EMS, a lot of the cost is cost of readiness. This is a lot of the expenses you guys all have, that's a lot of our fixed costs.

And then just more breakdown of the cost. That's maybe too small for you guys to read, I apologize. This is about the fiscal reporting guide, how important they are, and how some folks have been late with the fiscal reporting guides or late with the grant applications and have therefore been disqualified for grants. It's just really important for us to do that. In the next coming months, there will be new changes on fiscal reporting.

So this just is rates from a five-year period. And as you all know, costs just keep going up.

And the most recent change was March 24th of this year. That was a 6.35 percent rate increase. I've looked at the data.

First of all, the March 24th data that I analyzed was half the data I normally look at. And based on the full data that I looked at, the rates will stay the same for July for another year, unless there are big financial problems going on. But based on my data I've seen, the rates for March 24th will continue on.

This right here is showing the industry. EMS bills $171 million. The average collection rate is 54.97, so we generally get 55 cents on the dollar. There's a lot of write-offs with Medicaid and Medicare, bad debt, and things just uncollectible. I just want to give you an idea of where we are. And, you know, some agencies have a little bit better collection rates, some have a lot worse, depending on the payer mix.

You know, it's just about rate regulations and just where EMS is. We're stuck in the middle of all this. So I wanted to give you an update, annual update, for EMS rates.

Does anybody have any questions or anything?

MICHAEL MOFFITT: So are you saying that

there is no July increase?

ALLAN LIU: There's no rate increase or decrease. It stays the same since the March.

MICHAEL MOFFITT: So the March rate increase was actually catch-up from the July of last year increase that didn't happen until the fall --

ALLAN LIU: So July 1 rate --

MICHAEL MOFFITT: -- and because of the delays, we incurred more costs, that we lost money faster because of delays, and that's what the March catch-up was, is to put it back in parity from last July. And now you're saying that we aren't going to get an increase now, going forward into the next year?

ALLAN LIU: That's correct.

MICHAEL MOFFITT: That's wrong. I'm sorry. All of our data shows that that's not correct, that the EMS system statewide will suffer losses for another year, and that will put hardships on everyone from municipalities to county governments, especially the rural governments and private enterprise will all be hit significantly because of the failures of state Medicaid to keep up with the increases in rates.

They have not changed their rates -- in fact, we took two rate deductions in '08 and '09 from state Medicaid without even a bi-year lead, they reduced our

rate, that has not been brought back to where it should have been, and there's still no address from the state Medicaid, reimbursing EMS providers at 14 to 17 percent of state-approved rates. And the costs are still going up. And you're saying that we've got another year to go before we consider another increase? I'm just -- I don't see the logic in that.

ALLAN LIU: The data I looked at for the March 24th was, again, half the data, and that was a 6.35 percent rate increase.

MICHAEL MOFFITT: Will that --

ALLAN LIU: With the full data I received, going apples to apples, was a 4.59 percent rate increase.

MICHAEL MOFFITT: The March 24th rate increase was to make up the difference for the delay of several months from the July increase of 2013.

ALLAN LIU: July to October. July to October.

MICHAEL MOFFITT: July to October. The problem is that EMS -- and this has gone on for 30 or 40 years -- EMS has always been pay now, catch up later. So when you delay the July '13 increase, we've already spent that money, and we're hoping to come back to closer to parity and get a head above water and take

a breath before we go under again, and it was delayed longer.

And so the March increase was just to make up for the loss opportunity that we had between July and October when that partial rate increase went into effect. Now you're saying go another year and hold your breath under water. I don't know what you're examining or how you're relating it to the industry.

I'm talking from my position, but I'll bet a show of hands in here would show that almost everybody else agrees that July '15, 2015, is way too long to hold our breath under water. With the economy the way it is, with the costs that we have to put up with going up, and with Medicaid staying static and not changing in years. Those are -- those are issues that are significant for us, and I just want to point that out.

ALLAN LIU: I appreciate that.

MIKE MATHIEU: Allan, I'd just like to reiterate that in a different way. One of the challenges we're looking at is, if I look at my career in EMS, I remember when we first started in 1991 in transporting, the average collection rate, grossing it, was around 70 percent. And this isn't an issue with the bureau. It's an issue that we as an EMS committee, we need to look at, because rate regulation, as you

just stated, and the purpose for it, is the cost containment to ensure that we have a comparable, acceptable approach for delivery, that people are not gouged.

But the problem is, is our rate regulations are not regulating rates. All it's doing is cost shifting to those who can pay. And our real problem is the reason these rates are so high is because our legislature has refused to adjust, and even state Medicaid office, one of the striking comparisons I saw -- and this is not to make a combative issue between say physicians and ambulance providers, but one of the things the Medicaid executives explained to the legislative committee is that the physicians are being reimbursed at roughly 70 percent of what the Medicaid prevailing rate is.

Ambulance service providers are reimbursed at the rate of 35 percent of what the Medicare rate of ambulance reimbursement is. Ambulance services, as it relates to Medicaid, have been ignored for years in the state because they just assume we will provide the service regardless of what we're being reimbursed for.

The average reimbursement rate for an ambulance transport for a Medicaid patient is under $200, and so if I transport a Medicaid recipient, I may

see $200.

If I transport Mark Adams in an auto accident, I'll see $1800. Mark is paying for four other Medicaid patients, that's the reality of it. And if we don't address the reimbursement arena, not the rate regulation side, we will just continually cost shift and escalate to where things are so out of whack, we'd have problems with those people paying 14, 18, $2,000, that are paying for the five previous that did not pay. We have to address this Medicaid issue. It's getting so disparate, the difference in reimbursement is getting so wide. It's not you. I just want to have that on record.

KRIS KEMP: If we're going to continue with this, I think that likely what we need to do as a recommendation is that we ask for volunteers from this committee to work with Allan on the data review so that perhaps there might be a rate increase that's discoverable, once we reanalyze the data. So if there would be a volunteer or two from the committee that would like to rework the numbers with him, I think that that would be appropriate.

MICHAEL MOFFITT: I'd be happy to do that.

KRIS KEMP: Mike. Okay.

MIKE MATHIEU: I opened my mouth, so...

KRIS KEMP: All right, both Mikes. Anyone else? Okay.

ALLAN LIU: Go Team Mike.

PAUL PATRICK: Jay said he would.

KRIS KEMP: Jay, maybe you'd like to help participate in that and work and Allan, great. And then through this process, I think perhaps we can look at getting Medicaid involved in trying to figure out if there is a better way to rectify this ongoing and continuingly large problem. All right. Thank you.

ALLAN LIU: Thank you.

KRIS KEMP: Dr. Taillac here is reporting.

PETER TAILLAC: That didn't come out quite right. Okay. I can show you what we've got, though. So I don't know who here is completely familiar with the CARES registry. It's the Cardiac Arrest Registry to Enhanced Survival. And this is a national benchmark standard developed by the CDC and supported by the CDC. It's also kind of hosted nationally out of Emory University in their contract with the CDC.

But agencies all over the country, including EMS agencies and hospitals, have been providing data to this registry since its beginning about five or six years ago.

Two years ago, Utah committed to becoming one

of the first states to actually enter statewide data. And as many of you probably know, we have a coordinator, CARES coordinator, Chris Stratford, who has been collecting data from the agencies, primarily by culling it out of the Polaris database, and when needed, having some phone conversations with the agencies directly to clarify records.

But essentially what they're looking at is all of the cardiac based cardiac arrests. In other words, nontraumatic, nonpoisoning, nonhanging cardiac arrests, the ones that appear to have a cardiac etiology.

And so really for the first time, and as one of the first states in the country, I might add, we have statewide data on our cardiac arrest resuscitation rates. And what these are is survival rates of patients that actually have come out of the hospital with a CPC, a Cerebral Performance Category, of either 1 or 2.

And that basically means that they're either perfectly normal at 1, or they need limited support at 2, but they're able to essentially go back to work and do their own activities of daily living, that sort of thing. There's four categories in that. The 3's and the 4's are the nursing homes or the vegetative states,

essentially.

So this gives us the opportunity for the first time to actually measure at the agency level and for the hospitals who receive the patients, by the way, as well as the regional and the state level, our cardiac arrest survival rates. There's a lot of new news, as I know everyone in this room is aware, in cardiac arrest resuscitation. We've gone from say five, six years ago of the occasional save, and everyone's sort of surprised, to many agencies now attending cardiac arrests and being surprised when the patient doesn't get a pulse back, particularly when it's a witnessed ventricular fibrillation.

So I'm afraid it doesn't show as well as it did on my computer, but let me just show you, this is the national data. I'll just click back and forth. So overall, of all the cardiac arrests nationally, they had 36,000, 37,000 in the database, there's a 10.6 percent survival rate.

Here's Utah's, all agencies in Utah altogether, a 12.5 percent survival rate, so not bad for overall, and which includes asystolic arrests, which, as you all know, have a relatively dismal survival, although that's actually getting better as well.

If you look at the bystander witnessed survival, this shows how much improved your chances of survival are if a bystander witnesses your arrest, 16.4 percent, both in Utah and nationally.

So unwitnessed arrests, on the other hand, 4.4 percent, so look at the difference if someone sees you have your arrest versus not. In Utah, a little bit higher than that, it's 7.3 percent.

Now, the Epstein survival is a standardized measure of cardiac arrest survival that was published in 1991 or so and has some specific characteristics, and the most cogent of which are these are witnessed arrests where ventricular fibrillation is the first recorded rhythm, okay, so witnessed arrest that has V-fib. Survival rate in Utah was 28.7 percent, so not quite one out of three. Survivor rate nationally, 33 percent, a little bit better.

The Epstein bystander is a modification of that. It's the witnessed arrest that has ventricular fibrillation that also had bystander CPR applied, so these are the sort of the best of the best. Again, 38 percent nationally survival rate, 36 percent in Utah. Pretty much the same.

And this to me is information that can be used at the agency level, potentially at the hospital

level, particularly the EMS agency level, and also for us at the state office in public awareness campaigns, trying to encourage people to begin the very simple process of bystander CPR now that doesn't even involve any sort of mouth-to-mouth, et cetera. It's something that can be learned in five minutes, how to push hard, push fast, and don't stop.

So I'm really excited about this, that we have this data. We're going to continue collecting this. And each agency -- this should be toward the end of the summer, we're going to provide back to each agency their specific agency cardiac survival rates for cardiac arrest, with a comparison to the state and the national, essentially. And actually, we'll kind of do it regionally as well so each agency will be able to get their numbers back, and we will send those numbers back to them yearly as we collect this data every year. We'll also send the survival rates back to the hospitals as well, by the way.

So any questions about this data or how we're using it or suggestions on how best to use it? Sir.

KRIS KEMP: Is there any time listed in some of this data as far as down time, how long the person was down , how long before CPR was begun? Because I think that it might --

PETER TAILLAC: Not in the data points collected.

KRIS KEMP: Yeah, because it might extrapolate some of that data out for what you'd experience in kind of a rural area and what you would expect in an urban area, because if nationally we could say, well, in the big cities, our survival rates are higher because there's more medics everywhere and AED's are in every agency's back pocket, whereas --

PETER TAILLAC: And get to people quicker.

KRIS KEMP: -- it takes 20, 30, 40 minutes for us to get to some of our areas in rural Utah, or longer, you would expect the survival rate to go down --

PETER TAILLAC: Absolutely, yeah.

KRIS KEMP: -- significantly.

PETER TAILLAC: Yeah. We're going to look at that. We started to do some looking at the information in general. We started to look at rural versus urban comparisons, again, not to judge one versus the other, but to establish a benchmark or a baseline from which we can hopefully improve. All right.

KRIS KEMP: All right. Terrific. Thank you. Without the use of the mic, we'll do round table discussion specifically, and we'll start here, Jay, if

you have anything, and we can just move around.

JAY DEE DOWNS: I think this is great data, though, and some of these questions are really good, too.

KRIS KEMP: Okay. Jeri.

JERI JOHNSON: I just need to bring back up the discussion of the subcommittee and --

KRIS KEMP: The specific task being?

JERI JOHNSON: The specific task, that we have a plan and --

KRIS KEMP: Okay. Well, let's just make sure we're speaking up. The point was, you wanted to revisit and redistribute the --

JERI JOHNSON: -- policy.

KRIS KEMP: -- terms and attendance for task force members or subcommittee members. And then you also mentioned -- or we already moved on the committee assignments to represent for each subcommittee. Was there another one?

JERI JOHNSON: No, that's it.

KRIS KEMP: Okay. Any other assignments that need to be made specifically?

MARGY SWENSON: To the subcommittee?

KRIS KEMP: To the subcommittees.

JASON NICHOLL: I think we should have the

subcommittees, if they are interested, ask for volunteers for the -- for Dean's work groups --

KRIS KEMP: Okay.

JASON NICHOLL: -- follow up with them.

KRIS KEMP: Yeah, so let's make sure that that comes up as a task to the subcommittees.

JERI JOHNSON: We should discuss applications being processed also. We need to simplify it to be more on the subcommittees. Within the agencies it was too cumbersome, and help --

KRIS KEMP: And we can, I think, do that once we review what vacancies there are and we can address that --

JERI JOHNSON: Get the word out.

KRIS KEMP: -- from there. Other parties?

MARGY SWENSON: Yeah. We talked in the executive commission -- or executive session about tasking EMS with giving us a list of the various ambulance or EMS agencies and their level of service currently, along with any waivers that they have, so we can compare that around the state, because we don't have that information.

KRIS KEMP: And we'd like that within?

MARGY SWENSON: 30 days. Thank you.

KRIS KEMP: Great. So a task for the bureau

and for the department.

PAUL PATRICK: I have two.

KRIS KEMP: Uh-huh. Mark?

MARK ADAMS: I don't have anything.

KRIS KEMP: Okay. Brett?

BRETT KAY: (Shaking head.)

KRIS KEMP: Okay. Jason?

JASON NICHOLL: (Shaking head.)

KRIS KEMP: Mike?

MIKE MATHIEU: Nothing.

KRIS KEMP: Russell stepped out. Casey?

CASEY JACKSON: (Shaking head.)

KRIS KEMP: Laconna?

LACONNA DAVIS: (Shaking head.)

KRIS KEMP: Mike?

MICHAEL MOFFITT: Yeah, I'd just like to maybe task the operations subcommittee with looking at -- I noticed in the rules we still have all of the supplies and equipment lists for ambulance, and I know this is like a ping-pong ball, sometimes it's in the rules and sometimes we move it out, but I think it would be more nimble to change if it were out of the rules and it was like bureau policy for, you know, how many Band-Aids you have and backboards and equipment and stuff on the ambulances and drugs and that kind of

stuff.

But if the operations subcommittee could look at that and make a recommendation on whether or not to move it out of rules in -- the lists out of rules into the Bureau, so they can just keep a current list and keep us updated on it, rather than go through a process of rule changes when a drug changes or something, or we can't get a drug.

KRIS KEMP: Would that be best through operations or through the rules task force?

MICHAEL MOFFITT: Well, I think operations swings a broader net, so at first I think I'd like to start it there, the EMS provide input, and then if they come back and say, "Let's rewrite the rule to that," then we can go over to the rules task force.

KRIS KEMP: I think we took this up at one point in the second version of our rules provision committee, and I think what we were trying to shoot for was to put a in-rule recommendation to -- or in-rule statement, essentially referring to a separate document --

MICHAEL MOFFITT: Yeah.

KRIS KEMP: -- that was then managed by the Bureau through the committee. So maybe that is, I think, probably the easiest way to do it. So if we can

go to operations and say, "Can we do this as an option" --

MICHAEL MOFFITT: Yeah, and that's --

KRIS KEMP: -- "so we can manage that equipment list?" Guy?

MICHAEL MOFFITT: -- kind of what I'm looking for.

GUY DANSIE: Just a little background. We've had Lyle here as our legal counsel. He said that we shouldn't do that. Brittany's researched that since Lyle has retired, and Brittany's comfortable with us putting that in policy. And in that rule packet that we sent out, we've done that.

KRIS KEMP: Yeah.

GUY DANSIE: We plan to move that way. We can address it in the subcommittee as well. But that's our intent. And the same with the air ambulance portion, we were trying to move the criteria for accreditation and some of the new rules currently into policy. That was our goal working through the task -- the rules task force, and we can revisit that, if you'd like, with the subcommittee.

KRIS KEMP: I think that's probably appropriate, based on what Mr. Moffitt is requesting, that we have that go through operations as a final

once-over before it gets completed through the rules task force.

Lynn.

LYNN YEATES: (Shaking head.)

KRIS KEMP: All right. I think the only other point that I would like to make before we adjourn is notice of our next meeting is on October 15th. I think there's a few people that will not be able to attend that day. That gives us three months to look at alternate days.

Two days that I are -- that I'm looking at specifically are the Wednesday prior and the Wednesday after, the 8th and the 22nd of October. And so if we can either address that now or via some form of other communication. The 8th may not work, so the 22nd. Anyone with significant problems in the committee for the 22nd of October.

PAUL PATRICK: It's fall break, UEA, hunting season.

KRIS KEMP: Hunting season, all these things. 22nd of October, any significant problems?

PAUL PATRICK: And if we change it now, everybody should know. We'll put up posters and signs and fireworks.

KRIS KEMP: Happy Halloween.

MICHAEL MOFFITT: 22nd is fine with me.

SUZANNE BARTON: 22nd is fine.

KRIS KEMP: 22nd is fine. All right. So we'll try to get that out and make sure that all the additional members of the committee are well aware.

And then Paul?

PAUL PATRICK: Just before you adjourn, we did some remodeling at the Highland building, so for your next -- for the -- in the board -- in the auditorium we put a new sound system in, we have gooseneck microphones, like five of them, so when we're there in our meetings from now on, everybody will have a microphone in front of them.

We also have a new projector to project PowerPoints, and then TVs back behind, so when you're sitting there, you can see them. So we tried to do that to help us facilitate these meetings.

Today was different because we're -- obviously, we had our awards ceremony. But for the rest of them there, I think you'll find that that will be -- we'll be able to hear better, and there's also a microphone for the presenters to come to. So you'll have ability to have an improved communication verbally when we're there.

KRIS KEMP: Perfect. Do we have a motion to

adjourn?

JAY DEE DOWNS: So move.

MIKE MATHIEU: Second.

KRIS KEMP: A second. All in favor?

COLLECTIVELY: Aye.

KRIS KEMP: All right. We're adjourned.

(Meeting was adjourned at 2:45 p.m.)

--oo0oo--

C E R T I F I C A T E

STATE OF UTAH)
:ss
COUNTY OF SALT LAKE)

I, Angela L. Kirk, a Registered Professional Reporter, Certified Court Reporter, and Notary Public in and for the State of Utah, do hereby certify:

That the foregoing proceedings were taken on July 9th, 2014;

That the proceedings were reported by me in stenotype and thereafter transcribed by computer, and that a full, true, and correct transcription, to the best of my ability, of said proceedings so taken is set forth in the foregoing pages;

That the Original transcript of the same was mailed to Suzanne Barton, Bureau of EMS and Preparedness, 3760 South Highland Drive, Salt Lake City, 84114.

I further certify that I am not of kin or otherwise associated with any of the parties to said cause of action, and that I am not interested in the event thereof.

WITNESS MY HAND and official seal at Salt Lake City, Utah, this 30th day of July, 2014.

_____
Angela L. Kirk, RPR, CCR
License No. 108202-7801